THE EFFECTIVENESS OF CRISIS CENTER INTERVENTION ON THE ADAPTIVE BEHAVIOR OF MENTALLY ILL OUT-PATIENTS

A Senior Thesis

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A program analysis was attempted on the thirty day program offered by the crisis recovery unit in Bryan/College Station, Texas to mentally ill out-patients in crisis. Thirteen interviews were conducted with clients at least six months after discharge from the crisis recovery unit. The information from these interviews were used to assess the effectiveness of this program on the adaptive behavior of former clients. Domains of interest included residence, social support, symptoms, medication, criminal activity, drug use, leisure activity, and economic condition. Categories of mental illness included major depressive disorder, schizophrenia, schizoaffective disorder and drug dependence. Results are not generalizable, as less than 50% of the population was interviewed. Among those who were interviewed, however, depressed individuals expressed better progress when compared to members of other categories. Schizophrenics in this study showed the least improvement. Suggestions were made for improving the structure and content of this study. A commentary is included which discusses the possible benefits of employment on the adaptive success of mentally ill out-patients.

The Effectiveness of Crisis Center Intervention on the Adaptive Behavior of Mentally Ill Outpatients

A mentally ill client comes to the crisis recovery unit in the worst of conditions. The crisis center is a small building with a few beds and a modest budget. The mental health care providers in attendance must calm the client, re-establish a medication regimen and provide counseling in such a way that the client can be returned to a pre-crisis mental state and social capacity (Dixon, 1979). This sounds simple enough. Get the individual cleaned up and fed, get the medication straight, provide a physical and mental exam to assess the baseline state and clear a bed. Therapy can then be administered until the client is behaviorally and socially ready to return home. Of course, the need to prepare such individuals for a prompt exit exists, as the client has anywhere from ten to thirty days to become stable and socially adept enough to venture back on his or her own. The client will venture out, whether he or she is ready or not.

Funding is one of the biggest complaints of crisis center administrators (Roberts, 1995). Despite this serious problem, government funded crisis centers across the nation must try to treat the chronically mentally ill in times of crisis with the best quality possible in a minimal amount of time, and it is no simple task. There are no specialists in the disorders of schizophrenia, depression, etc. at these locales. Any person with any disorder will be treated in the same group therapy sessions with those suffering from different disorders simply because the crisis center cannot afford to specialize. The quality of individual care can be provided better at well-funded institutions, but the crisis centers of interest in this study tend to be non-profit organizations, supported by tax money paid by the community. The clients come here because they have no way to pay for the services they need. It is not difficult to see that funding such a community

service organization is a risky investment, because it may be the case that the program being offered will not help clients in the long run, and crisis center budgets are cut regularly. This is unfortunate because these programs, however limited in scope, can make a difference in some areas of a client's lifestyle.

One would assume that programs which serve the mentally ill are helping the individual not only to understand and cope well with his or her affliction, including adhering to the assigned mediation regiments, but also helping the individual to become a socially adept and productive member of society (Carling, 1995). For any person to become a viable and successful member of his or her society, that person must be able to tend to personal and essential needs and be able to accept and respect his or herself. In addition to maintaining the physical safety of the client, the goal of public service organizations such as community mental health crisis centers should be to bring about this important end for the mentally ill outpatient: self-respect, self-maintenance and independence (Carling, 1995). Social and economic self-reliance and success will materialize upon the foundation of these three factors.

By definition, a crisis recovery unit should put the client back on his or her feet and work with the person to establish a lifestyle which is conducive to personal health and independence. An antecedent to this outcome is the establishment of strong adaptive behavior, that is, basic "survival skills." Before one can join the world of employment, relationships and accomplishments, that person must be able to provide food for his or herself on a healthy interval. That individual must be able to maintain a hygiene level conducive to good physical health. The individual must have mobility, in as much as being able to get around competently in

the neighborhood. Essentially, the person with good adaptive behavior can be left alone to protect and care for him or herself, with no aid from a care giver.

After patients' symptoms are stabilized (sometimes with the help of medication), most crisis center intervention programs address the adaptive behavior issue above all things. Many also offer job assistance and aid searching for residence (Grossman, 1978). Particularly helpful are programs which include instruction in such areas as medication (what the medicine treats and what it affects physiologically) and its proper management, disorder definition (defining particular disorders to the client and explaining the affects and the treatments) and coping skills for life events (often for events which precede problems that bring a person to seek crisis center intervention) (Grossman, 1978; Dixon, 1979). Crisis centers can provide in-patient treatment, complete with clean rooms, meals and daily structure. Creating medication schedules and completing physical and mental health examinations help mental health providers establish personalized service and personal and group counseling needs; unlimited access to counseling is paramount (Grossman, 1978). Daily guidance and a daily routine remind the client that daily activity and communication are key elements in the lives of socially and physically healthy people (Willer, Guastaferro, Zankiw & Duran, 1992).

If research identifies an area in which many former clients are weak, the crisis center can use this information to enhance certain aspects of the program so that the particular problem can be resolved for future clients.

In Bryan/College Station, Texas, the Brazos Valley Mental Health and Mental Retardation Authority (MHMR) supports a crisis recovery unit. This unit serves its community by taking in severely mentally ill individuals in crisis, providing shelter and food for thirty days,

establishing medication schedules, and conducting personal and group therapy on a daily basis for the duration of the client's stay.

Group therapy sessions fill the day all week, each offering a distinct focus. Traditional therapy allows the clients to take turns talking about the issues with which they have been dealing and gives others in the group an opportunity to offer guidance and understanding. Educational groups teach the client about his or her medication, its purpose for the ailment being treated and its side effects. It is often the case that a client will not know why he or she is taking the prescribed drug or why he or she is suffering particular side effects; these classes not only help the individual understand his physical and mental "anomalies" but also recognize these conditions as side affects. Learning about the disorders helps clients to understand the nature of their individual illnesses, to include symptoms, behavior signaling relapses of the disorder and means of anticipating destructive behavior and dealing with destructive behavioral patterns. Coping classes teach clients the cycles of emotion (for example, the cycle of the reaction to trauma or guilt) and proper methods for negotiating the stages. Learning to cope with the unexpected and the common events in life should promote adaptive behavior and proper social behavior at the most difficult of times (Bennett, 1980). Physical fitness and creativity sessions bring out a sense of personal worth and accomplishment in the client; the client actually participates in behavior that induces feelings of pride and peace. In theory, the client released from the center and living without aid will practice such exercises when thought patterns materialize which create a sense of worthlessness or chaos within because of remembered positive experience during therapies of this type (Brook, 1993).

The present study was designed to evaluate the long-term effectiveness of this thirty day program. Former clients of the crisis recovery unit were interviewed six months after release, the daily living situation and the general condition of the client were recorded and this information was compared with information taken at time of admission.

Method

Participants

Thirteen mentally ill out-patients volunteered to participate in this study (9 women and 4 men, mean age = 34 years). Four of the individuals were schizophrenic, five suffered from major depressive disorder, four had schizoaffective personality disorder and four dealt with some form of chemical dependency (due to dually diagnosed individuals, categories overlapped into the area of chemical dependency). All subjects live in or near the community of a major southwestern university. The average age of the subjects in this study is 34 years.

The Structured Interview

In order to assess the adaptive behavior of former clients of the crisis recovery unit, domains of interest were established. Several established instruments were used to construct a structured interview. The Vineland Adaptive Behavior Scale was used as a basis for building the interview. This scale was created in the 1940's and was used in the area of institutionalized mentally ill. Domain ideas borrowed from the Vineland Scale included Personal Hygiene, Symptom Coping and those related to Social Competence (although the content questions are original). However, because the Vineland Scale assessed populations which rarely dealt with society and social issues, many domains did not seem compatible with the population of interest in this study. Therefore, other scales were examined. The Multinomah Community Ability

Scale proved useful because it addressed some social interaction domains. Issues of independence and daily coping with disorder issues were assessed, as well as those of social effectiveness, networking and meaningful activity. The crisis center's own Client Satisfaction Questionnaire for the Day/Evening Program also pointed the researcher in the direction of what general questions needed to be asked. The Texas MHMR Mental Health Family Members Survey was a model for assessing the domain of Support System as well as some questions in the domains of Residence, Symptoms and Medication. A form (uncopyrighted and anonymous) entitled the Client Data Summary Sheet was already in use at the unit and contained many valuable domain ideas. The sections on Drug Use, Employment, General Health and Criminal Activity in the behavior scale used in this study were influenced strongly by the emphasis of these issues in the Client Data Summary Sheet. We introduced other domains include Mobility, Finance Management, Nutrition, Leisure and Accomplishments/Future Plans.

Questions for all domains are original, as well. The interview protocol is included in the appendix of this thesis, and served in the capacity of a structured interview as the researcher made contact and interviewed former clients of the crisis recovery unit. See Appendix A to view adaptive behavior scale used in this research.

In addition to the protocol used for the structured interview, an informed consent document was created, as required by the American Psychological Association (American Psychological Association, 1995). See Appendix B to view the informed consent document used in this research.

Design and Procedure

A list of clients released from the crisis center in both May and June of 1996 was obtained, along with addresses, phone numbers, significant others and DSM-IV diagnoses. The admissions employees at the unit had not asked all the questions salient to this research, so very little comparison could be made between old and new documented information (as was the initial design of this research). Much emphasis would be put on the responses in the interview and general observation of the individual and his or her environment.

From the May list (consisting of twenty-nine names), calls were made and interviews were scheduled for eight individuals in October. Most of the others had disconnected phones; some no longer lived at the address indicated. Often, significant others either could not be contacted or could not provide information on the location of the potential subject. Three individuals turned down the opportunity to interview and one former client had died shortly after release from the crisis center. Although information could not be gained on the daily activity of this population, the fact that the individuals were either unattainable by typical means or not in contact with significant others speak to each one's status in the domains of residence (stability) and social support. Three subjects from the June list of twenty individuals were contacted and interviewed. Twenty-five percent of individuals on this list were also on the May list; every other potential subject for this month had disconnected or no phone. Time limitations did not allow for home-searching excursions into the city.

Save two, all interviews were conducted in the residence of the former client (the others were conducted in a restaurant and at the crisis center, where the individual had returned as a result of mental health crisis). The structured interview as well as general discussion lasted an average of twenty minutes. During this time, in addition to conducting the structural interview,

the current concerns and needs of the individuals were discussed. The phone number for the crisis center was distributed periodically and encouragement was given to those who answered positively to questions in the Goals/Accomplishments domain.

Results

Because there existed very little information on the clients with regards to their condition upon admission to the crisis center, the analysis was done on the information obtained in the interview sessions. Admissions information was used only to distinguish among disorders. Critical questions in the interview are of the simple positive/negative type; therefore, each could be coded by binary methods (positive=1; negative=0). Percentage of positive and negative answers were calculated based on sex of the client and on the mental disorder, to include Schizophrenia, Major Depressive Disorder, Schizoaffective Disorder and Substance Dependence. These results are presented in Table 1.

All had residence save one, who lived at the crisis center and categorized as homeless; only two subjects lived alone and independently. Residence stability was exceptionally good for the majority of the group, as none reported moving around much since discharge; the majority remain where they had lived before entering the crisis center. Ninety-two percent, or all but one, of the group remain close with family members and friends. Only four of the sample are driving, most using the local mass transit system or walking. Only one person is employed; all others are disabled and receive welfare funding from the government. Only 54% of the group felt physically healthy at the time of the interview; 64% were exercising regularly at the time, most of those being women. Fifty-four percent of the sample were of the opinion that their symptoms were getting better and all but one were taking their medication properly, although only 64% were making their medication check appointments with MHMR. Without exception, all subjects

were able to describe in detail the medication plan they were using, to include medication names, milligrams per day, number of times per day and what each medication was intended to treat. More often than not, the medication was within arm's reach of the individual being interviewed. No subject had resorted to criminal activity since discharge, although one male and one female each participated in a physical fight. No subject used illicit drugs or alcohol since discharge. Sixty-nine percent of the clients participated in particular hobbies (all the men). Only 38% had begun education since discharge, but 69% agreed that personal relationships had improved over the months since discharge and all save one could describe personal goals for the future. Sixty-one percent of the clients expressed a sense of accomplishment in some recent activity, although none of these were schizophrenics. The statistics show that depressed people fare better overall as a result of their treatment, as this group has the highest percentage of positive answers in virtually all domains of interest. Schizophrenics as a group may not often make medication check appointments compared to those in the other categories. Sufferers of Schizoaffective Disorder are progressing well in most domains, except in that of Symptoms. People suffering from Chemical Dependence tended not to fare well in the domains of Nutrition and Exercise and generally do not feel healthy physically.

	Overall (N=13)	Male (n=4)	Female (n=9)	Schizophrenia (n=4)	Depression (n=5)	S. Affective (n=4)	Chem. Dep. (n=4)
Average age	34	32	35	36	30	37	40
RESIDENCE							
Have home	92%	75%	100%	92%	100%	100%	92%
Living alone	15%	25%	11%	25%	0%	25%	0%
Stability	100%	100%	100%	100%	100%	100%	100%
FAMILY							
Closeness	92%	100%	89%	100%	80%	100%	100%
Friends	92%	75%	100%	75%	100%	100%	100%
ECONOMY							
Driving	31%	25%	33%	0%	20%	50%	75%
Job	8%	25%	0%	0%	20%	0%	0%
Welfare	92%	75%	100%	100%	80%	100%	100%
PHYSIOLOGY							
Healthy	54%	75%	44%	75%	40%	50%	25%
Exercise	64%	25%	78%	50%	20%	100%	0%
SYMPTOMS							
Better	54%	75%	44%	75%	60%	25%	50%
MEDICATION							
Taking med.	92%	75%	100%	100%	80%	100%	75%
Med. Check	64%	0%	89%	25%	80%	75%	75%
Description	100%	100%	100%	100%	100%	100%	100%
DELINQUENCY							
Criminal act.	0%	0%	0%	0%	0%	0%	0%
Fights	15%	8%	11%	0%	20%	0%	0%
Drug Use	0%	0%	0%	0%	0%	0%	0%
QUALITY OF LIFE							
Hobbies	69%	100%	56%	75%	80%	50%	50%
Edu. Change	38%	50%	33%	25%	40%	50%	25%
Relations	69%	25%	89%	25%	100%	75%	75%
Accomplish.	61%	50%	67%	0%	80%	75%	75%
Goals	92%	75%	100%	75%	100%	100%	75%

Table 1 - Response percentages, grouped by diagnostic categories

As the interviews accumulated, it became apparent that few significant problems with regard to adaptive behavior existed. All could feed themselves and get around town effectively if

not conveniently; however, some were not taking care to keep themselves safe from harm. Although each person interviewed was in a safe place and had some form of income and care-taking, there were a few individuals who, since discharge from the crisis center, have been physically victimized. A new concern materialized as the interviewing moved on, that of recidivism. Relapse is a common result of life trauma as well as long bout of inactivity. This problem will be addressed in the Discussion portion of this presentation.

Discussion

It seems to be the case that some domains were affected by the work of the mental health crisis center. Although there is no admissions data with which to compare this, there are some outstanding percentages of positive answers in particular domains, which could not logically have existed prior to crisis intervention. The positive feedback in the domain of Medication was particularly encouraging. One hundred percent of the sample is taking medication independently of care giver assistance. This is quite promising. Establishing a solid and consistent regimen for medication administration is the foundation of all future success for the mentally ill out-patient, and the crisis center in Bryan affected this progress through its education classes, personalized regiment assignment and monthly contact with out-patients for the sole purpose of supplying medication and maintaining its proper usage by the client.

Drug Use in another domain to which this group of subject responded positively. One individual admitted to drinking a toast on New Year's Eve, and another confessed to drinking one beer a few days before; otherwise, no subjects had partaken of any illicit drug or alcohol since discharge from the unit. Upon arrival of the client in crisis, the possibility of drug usage is assessed and the individuals whom use are required to attend Alcoholics Anonymous (AA).

Although this organization does not have a history of 100% success, it seems to be working as such in this sample. Long after release from the crisis center, individuals at risk are still going to AA meetings and apparently benefiting from their association with that group. This is a result of the providers at this crisis center to provide free transportation to the meetings and education with regards to drug abuse, its consequences and the behavior and thought patterns which often lead one back to the drug of choice.

The Criminal Activity domain is practically devoid of affirmative responses. One woman was physically assaulted by her mother and fought back; another was attached by drunk men on the street while with friends. Neither of these episodes concluded with police intervention, however, which means that the subjects in question were able to handle the situation independently. Virtually all subjects were not only maintaining relationships with family and friends, many believed that relationships had improved since discharge and are a result of the crisis center intervention. Much of the therapy at the crisis center works to teach the client communication technique and how to respond to the unexpected responses and behavior of others.

Individuals with Major Depressive Disorder seem to be fairing best among the categories of disorders. All express in detail personal goals and ambitions as well as recognizing personal accomplishment. More depressed individuals expressed a desire to return to work than in other disorder categories.

Schizophrenics show less progress than the other groups, especially in the domains of Leisure Activity and Goal/Accomplishments/Future Plans. They are on strong and consistent

medication regimens, which is a great start. However, in general, they cannot see the possibilities for themselves in the future.

The one individual in this study in employment is one diagnosed with Major Depressive Disorder, single episode. Other than this individual, no subject holds a job; all are welfare recipients. Most of the subjects have not looked for a job and say that they do not look for work because they receive welfare funding. Furthermore, less than half the population drives or can be described as being freely mobile in the community (no schizophrenic has free access to a personal vehicle). It is the case that the crisis center works for the client to obtain federal assistance or have this assistance returned to him or her. Mentally ill individuals do have obstacles to negotiate in the world of employment opportunity, and federal support allows the client in need to step away from the crisis center and the support group and initiate a life of his or her own. There also exists job placement assistance at the center; the subjects in this study were either not given the opportunity to use this service or turned down the opportunity.

Since there is little admissions information one cannot know with certainty if progress in the lives of these people is a result of the intervention or if it is a product of some other factor or factors. It would seem that the individual personality of each person works to affect the direction in which daily life will move. Condition of the support system and economic factors certainly would affect the mood and motivation of these people as they do for most people with and without mental illness. Surely, these factors play a part in the state of affairs for each individual today.

The most problematic area of this work lies in the exceptionally small sample size. Of 44 possible subjects, only 13 were interviewed. Although assumptions might be made about the

stability and social support system of subjects which were not contacted, nothing can be said of their progress in any other domain. Random selection was not achieved in this work. The small sample size cannot possible be representative of the entire population of clients serviced by the crisis center. With time, many more subjects could have been interviewed, which would have allowed for some type of generalization to the population of interest. The information obtained in this study, however, does not allow for a realistic generalization as to the progress of the population of mentally ill outpatients serviced by the crisis recover unit. In order to increase the representativeness of the sample, the time and funding must be committed to finding all of the released clients. Travel is an integral part of this endeavor, and one must have the resources and the time to follow every lead which may end in making contact with a former client.

Additional domains should have been added to the structured interview which more directly tap into the problem of recidivism. One of the biggest problems a crisis center tackles is the reappearance of familiar faces. During interviews, two individuals reported returning to the crisis center at least once. Others reported going to a hospital emergency room with symptoms typical of their disorder (which makes one wonder if these subjects are being truthful in their responses within the Medication domain). Possible domain questions might ask about the number of times an individual has returned to the unit and under what conditions did an individual feel the necessity to return to the unit.

Another weakness of this study was the inability of the researcher to acquire detailed information about the physical and mental condition of the subjects upon arrival to the crisis center. Absolutely no comparisons could be made among documentation. The research relied on assumptions about the likelihood that a subject was in a certain state based on a general

definition of "mental health crisis." No sophisticated analysis can be attained without this information.

MHMR and the crisis recovery unit in Bryan/College Station, Texas have worked diligently to help individuals without supportive families to obtain shelter for themselves in government funded housing. This organization also helps clients in need obtain federal support so that some semblance of financial independence can be had; personalized money management assistance has been provided to the majority of the subjects in this study. Medication check appointments are established so that the client may return to the unit for medication monitoring, and keeping in touch with the mental health care provider reminds the client of his or her medication requirements and schedules. This is probably the main reason for the high success rate of the subjects in this study in the domain of Medication.

There are things a crisis center can do to facilitate the ease of a program analysis, things which should be considered by a researcher when choosing a program for study. Maintaining complete and accurate location information on each client is paramount in the process of locating potential subjects. Certainly, detailed information is obtained in some form on incoming clients to the crisis center, but this information is of no use to the unit when it is not available for later reference and usage. Access to accurate and detailed admissions information is a must.

The crisis center in this study was quite interested in the idea of interviewing former clients and learning about their condition and the effects of the program on the population. If crisis centers such as this one are sincerely interested in learning about their programs' effectiveness and making changes to better serve clients, a good idea may be to employ an on-site program analyst. This professional and his or her assistants could be present during initial

review of the client's situation. An effective adaptive behavior scale or structured interview could already have been acquired and could be completed at the time of admission. The same professional could maintain the records of the client and include the scale or interview responses in this filing system. The analyst could weekly or daily arrange visits with former clients and obtain information identical with (or at least similar to) the admissions information. Not only would a position of this nature produce more reliable analysis of the programs offered at crisis centers, it would give the crisis center valuable information on the effectiveness of the programs providers work so diligently to implement. These crisis centers are supported by the tax-paying community; it is in the best interest of the community that these programs work effectively. Without significant follow-up work on former clientele, there is no way of knowing if the programs are working at all.

During the course of interviewing, many subjects took it upon themselves to express appreciation for the help they received from the crisis center in this study. Many feel that the progress they have made is a direct result of the efforts of crisis center staff. One subject actually said that seeking help with this particular crisis center was her best accomplishment in years. These comments cannot be ignored, and the crisis center offers quite a program for individuals who have no financial means of going to private, more specialized providers. If this crisis center produced twelve or thirteen individuals who can rely on themselves to take medication properly and remember the valuable lessons learned under the crisis center's program, then the funding is not going to waste. This researcher is of the opinion that every life is worth the effort to make better, and saving even a single person is worth the money.

Follow-up studies of clients offer something other than good program analysis. In addition to enhancement of provider services, studies have shown that follow-up visits to former clients actually increase the positive outcomes for them. Remaining in contact with mental healthcare providers gives the client sense of emotional and professional support.

A more accurate indication of the well-being and health of the client can often be attained by making short visits periodically to the homes of clients. Basic counseling in the way of communication and motivation can be administered in this setting and can benefit not just the client but the family members in attendance, as well (Cohen, 1990). Follow-up visits allow for the opportunity to meet with family members who might otherwise never make contact with the professionals who work to help and heal their relative.

Some studies support the idea that regular follow-up visits to the homes of former clients relieves and reduces the symptoms of mental illness in the client (Cobb, 1995; Lehman, 1995). Others indicate improved social skills as a result of the continued personal contact of health care professionals. Naturally, the clients (at least the ones in this study) express appreciation for the special attention given to them by people willing to take time out of busy schedules to check on their progress. When others display concern and kindness to the client, he or she may feel worthy of this concern and begin to show concern for and kind to his or herself. The visits give the client a sense of value in the larger community and a sense of worth to a group of people whose opinion is salient to his or her daily life. This benefit of follow-up cannot be emphasized enough. Quality follow-up contact with clients improve both the quality of work a provider can give and the quality of life a client can live.

Comment

A valuable outcome of successful adaptive behavior in this society is independence. Not only to be able to care for oneself physically, adaptive behavior should facilitate the ability of the client to support him or herself with individual effort; this promotes a sense of pride (Goldsmith, Veum & Darity, 1996).

Although the crisis center in this study works hard to acquire housing for clients, the clients in this study and others with which I have spoken do not seem motivated to be financially independent. Many clients, once deemed disabled by their mental illness, may not be encouraged to seek out employment. Instead, money management aid is given so that what money a client receives from the government will be spent properly.

Many depressed subjects in this study expressed a desire for better residence and more money, but also stated that they were not looking for work because they had been diagnosed as "disabled." Others talked candidly about the high quality of their leisure activities, and would promptly follow with the statement, "I'm not satisfied with my leisure activities; I'd rather be working."

The problem of recidivism in the population served by this crisis center might be significantly reduced if there existed a strong career training program in the context of the program currently being offered. Encouragement in the direction of employment possibilities could be given in addition to the assistance given to obtain welfare payments. It is true that these individuals need help getting back into society. But obtaining welfare benefits seem to be their final step in this process of returning to society. It might better serve as a form of support to the individual as he or she searches for the kind of job that compliments the type of person he or she

is. The crisis center in this town is quite small. A small number of career counselors or trainers might be all that is needed to enhance the current program. The progress already being made by this group may be strongly compounded as a result.

Many studies support the claim that employment actually reduces symptoms in the mentally ill out-patient, particularly among the depressed and even among schizophrenics (Cobb, 1995; Lehman, 1995). Bell, Lysaker and Milstein studied the positive affects of employment on the symptoms of schizophrenia; "Pay subjects worked more hours, earned more money and showed more total symptom improvement at follow up, and more improvement, particularly on positive and emotional discomfort symptoms" (1996). Anne Birch wrote a comprehensive piece on the attitude that many mentally ill people have regarding employment opportunity, entitled *What Chance Have We Got?* Therein, the patients being interviewed express hopelessness with regard to employment (Birch, 1983). Although the subjects interviewed in the presence study did not express hopelessness, many stated that they had no intention of searching for a job because of their diagnosis as disabled. Comments from the book *Return to Community* by Paul J. Carling sound similar to the stories told heard during interviews.

> "The problem that we're facing is that, similar to the physically disabled and the developmentally disabled, the mental health system, and a large part of the general public, believe that we are not capable of living independently, and believe that we must live in situations that give us care and treatment for the rest of our lives. That's the myth we have to debunk." (p. 1)

I would like to close this commentary with the following words by author George Bennet, who wrote *When the Mental Patient Comes Home.*

> "If we are to be helpful to the recovering mental patient, we must accept the basic attitude that *nobody* is totally helpless. No matter how severe a disability may seem, the person suffering it can improve. Granted, persons who have experienced massive damage in their brains, who are profoundly retarded, may seem at first to be totally incapable of helping themselves. A second look, however, reveals that even those with the most debilitating damage can respond to care, love and a firm challenge." (p. 15)

These individuals need to be taught to want more. Independence thereafter will follow. From this research opportunity , I take this newfound conviction. I also take with me the desire to help.

Appendix A

Residence

1. Where are you currently living?

2. Are you living alone or with someone?

3. How long have you lived at your current residence?

4. Have you moved around a lot since you left the crisis recovery unit?

5. How do you feel about your living arrangements?

Support System

1. Do you have any family members living in town?

2. How often do you contact them?

3. Are you close with any members of your family?

4. Do you have any friends in town?

A. If so, how often do you contact them?

5. Do you feel that you can call your case manager when you need help?

6. Who do you count on for support when you are having trouble?

Mobility

1. Are you driving?

A. If so, do you have access to a car?

B. If not, how are you getting where you need to be from day to day?

Employment

1. Do you have a job?

A. If so, where are you working?

B. How many hours do you work?

C. How much are you paid per hour?

D. How long have you had this job?

E. How do you feel about your job?

F. If not, have you looked for work?

G. Are you currently looking for work?

H. What have you done to find work?

I. Who have you asked to help you?

J. Have you asked for help from MHMR, TRC?

FINANCIAL

1. What are your sources of income?

2. Do you have any help managing your money?

A. If so, describe this arrangement.

B. Are you satisfied with it?

GENERAL HEALTH

1. Do you feel healthy overall right now?

2. How many times have you fallen ill or had even minor health problems since your discharge?

3. Have you gone to the hospital or emergency room for any reason since your discharge?

NUTRITION

1. How many meals did you eat yesterday?

2. Is that typical for you?

3. Do you snack throughout the day?

4. Have you had any weight gain or loss since you left the crisis recovery unit?

5. When was the last time you ate some fruit?

6. How many times a week are you eating fast food?

7. Are you exercising in any way?

SYMPTOMS

1. What kinds of symptoms of your mental illness have you had since your discharge from the crisis recovery unit?

2. Are your symptoms interfering significantly with your daily life?

3. Do you have more or fewer symptoms since your discharge?

4. Are your symptoms better, worse or the same as they were since you left the crisis recovery unit?

MEDICATION

1. Did you take your medication today?

2. Have you had any trouble getting your medications?

3. Are you suffering from any side effects now?

A. If so, what are they?

B. How severe are they?

4. Have you suffered from side effects since your discharge?

A. If so, what are they?

B. How severe are they?

5. Did you make your last medication check appointment?

6. Can you describe your medication plan to me now?

CRIMINAL ACTIVITY

1. Have you received any tickets or been arrested since discharge?

A. If so, where were they for?

2. Have you been in any fights?

A. If so, what was the situation?

B. Did the police get involved?

DRUG USE

1. How many times have you consumed alcohol in the last two weeks?

A. If so, how much?

2. How many times have you used marijuana in the last two weeks?

3. How many times have you used cocaine in the last two weeks?

4. How many times have you used heroine or other opiates in the last two weeks?

5. How many times have you used methamphetamines, such as speed or crystal in the last two weeks?

6. How many times have you used hallucinogens, such as LSD, PCP or ecstasy in the past two weeks?

7. How many times have you used downers in the past two weeks?

8. How many times have you used inhalants in the past two weeks?

LEISURE

1. What do you do in your free time?

2. Do you have any hobbies?

3. Do you set aside time just for yourself?

4. Are you satisfied with your leisure activities?

RECENT ACCOMPLISHMENTS/FUTURE PLANS

1. Have you made any educational changes since your discharge, such as working on a GED, taken classes, or received special training?

A. If working, have you received any specific training or recognition at work?

2. Have you had any positive changes in family or friend relationships?

3. Since you left the crisis recovery unit, have you done anything large or simple which you consider an accomplishment?

4. Do you have goals for the future (the next few weeks or months)? For example, exercise, education, improving relationships, changes at work such as more hours or getting a different job

Appendix B

I, _____, understand that I am being interviewed by a research student from Texas A&M University and volunteer of the MHMR Crisis Unit about myself to gain information about the effectiveness of the MHMR crisis center unit. I understand that if there is any question that I feel uncomfortable addressing, I may choose not to answer and I can choose to stop the interview at any time without fear of ridicule or any type of repercussion. Although the information provided may be added to my file with MHMR's crisis recovery unit, I understand that it will also be used as data in a research project and that my name will be kept confidential; information labeled with my name will not be discussed with anyone other than myself. I understand that any information I give will not be used to the detriment of any other person or organization, to include the crisis center and its staff. Strictly research, this information and any literature which results from it will not be publicized to any news group or public agent. I understand that the only place this data will be published is in the Evans Library at Texas A&M University and possibly in a refereed, scientific journal.

_____ _____

Signature of interviewee Date

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